ATTACHMENT

Sample HCFA 1500 claim form for dental sealants submitted by a HealthCheck nursing agency

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Recipien																			
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EMPLOYER'S NAME OR SCHOOL NAME							c. OTH	IER ACCID	C. INSURANCE PLAN NAME OR PROGRAM NAME										
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INSURANCE PLAN NAME OR PROGRAM NAME							10d. RESERVED FOR LOCAL USE					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO **Mark to and complete item 9 a-d.							
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE authorize the release of any medical or other information necessary											In June 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for								
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